April 2011
The Focal Point

Ann M. Busche
Director

We continue to watch what's happening at the State Capitol; the House and Senate have both released the details of their plans to fix the $5 billion state deficit. Attached is a pretty nice summary of the Governor's proposal, the House proposal, and the Senate proposal; we've added our best estimate as to the impact to PHHS budget.

Of course, all this is subject to change. If you remember your civics lessons, the house and senate must have identical language before each can pass, and it can go to the Governor's office for signing/veto. This means a conference committee, made up of House and Senate members will begin to meet soon to hammer out a compromise between the two versions. It will then be up to the Governor to decide if he signs it into law or vetoes some or all of the provisions. The statutory deadline for this session to complete its work is Monday, May 23. So, stay tuned.

Some good news as far as budget; we ended our 2010 budget year $3.2 million to the positive. How'd we do that? Well, we had about $900,000 in personnel savings, primarily due to people retiring, the position being open for some time between when the person left and the new person started, and the new person starting at a lesser salary. Seems like a lot of money, but when your personnel budget is about $41 million, this is a 2% variance, not a lot of wiggling. We had increased revenue; primarily child welfare targeted case management, and increased revenue due to one time federal stimulus money (this will go away on July 1, 2011).

Normally, when we end up with a positive balance, the balance gets automatically reserved for cash flow and for vested sick leave. We are now at 100% reserved in these two areas – first time in perhaps history of department – so Administration has reserved these dollars in two ways: 1) the $1.2 M in one-time money from federal stimulus has been reserved for future one-time investment in ways to help us do our work better, probably technology, and 2) $1.9 million has been reserved as a "hedge" against the impacts that are coming our way from the fix of the $5B state deficit. I know these past few years have been tough, and we've acted conservatively in our budget decisions; we are now benefiting from those decisions and will use these funds to soften the blow.

As always, if you have questions, comments suggestions, successes, or anything you want to share with me, please send me an email, call 2097, stop up in GSC 605, or stop me in the halls when you see me in Virginia, Hibbing, or Ely. **Ann**

Topic	Governor	House – HF 927	Senate – SF 760	County Impact
Chemical and Mental Health	CCDTF county cost share increased from 16.14% to 22.95% Increase to expense budget by an estimated $360,000	CCDTF county cost share increased from 16.14% to 22.95% Increase to expense budget by an estimated $360,000	CCDTF county cost share increased from 16.4% to 29.75% Increase to expense budget by an estimated $720,000	1 – cost shift to counties Increase to expense budget with no increase in revenues to support
Chemical and Mental Health	--	County cost share increased for MSOP from 10% to 30% Increase to expense budget by an estimated $360,000	--	1 – cost shift to counties Increase to expense budget with no increase in revenues to support
Chemical and Mental Health	--	--	Adult MH grant reduced 10% Decrease of revenue budget by an estimated $296,000. Decisions would need to be made regarding expense budget.	2 – direct county funding cut This grant funds 9 staff and funds county share of MH TCM contracts with RMHC and HDC. Remaining funds are contracted out to area providers. Reduction in revenue with no clear decrease in mandates.
Chemical and Mental Health	Restricts eligibility for residential treatment to persons scoring at a level 4 on assessment (or higher) dimensions related to relapse, continued use,	Limits residential CD treatment for an individual to no more than 3 episodes in a 4 year period and 4 episodes per lifetime (House Article 9, Section 6)	Restricts eligibility for residential treatment to persons scoring at a level 4 on assessment (or higher?) dimensions related to relapse, continued use, and recovery environment (Senate Article 2, Section 2)	4 – indirect impact Impact is to people we serve

	and recovery environment (Senate Article 2, Section 2)			
Child Support Enforcement	--	Eliminate child support enforcement incentive grants ($6.7 million)	Eliminate child support enforcement incentive grants ($6.7 million)	2—direct cut to county funding This was anticipated and budgeted; no impact.
Children and Family Services	Adds additional $12 M to adoption/ relative custody assistance to restore the base appropriation and fund additional caseload growth. Neither house nor Senate funds this provision.	--	--	1 – cost shift to counties Should the concept of Northstar pass without the corresponding revenue, it would increase expenditure budget by approximately $850,000+.
Children and Family Services	CCSA reduced by $5 million Increase to revenue budget by $567,000	CCSA is not reduced Increase to revenue budget by $850,000	CCSA reduced by $22M ($10 & $12) Increase in 2011 to revenue budget by $287,000. Decrease in 2012 revenue budget by $383,000	2 – direct county funding cut A certain level of cut was anticipated and budgeted for; decrease in revenue without corresponding decrease in mandates
Children and Family Services	Reduce MFIP Consolidated Fund by $10M Unknown	Reduce MFIP Consolidated Fund by $28M Unknown	--	2 – direct county funding cut The entire MFIP allocation is $108.6 M; 90% federal and 10% State. State portion is $10.8 M. Unclear how federal funds will be redistributed to unable a $28 M

				cut. 1.0 FTE is funded by allocation; remaining is contracted to providers or directly to clients.
Children and Family Services		MFIP EBT: if clients are not allowed to access cash for non-food support (Article 1, Section 12)		3 – new mandate Funds directly to clients; if counties need to make all payments, means extra responsibility with no increase in revenue to do this extra work.
Children and Family Services	No reductions in final budget	Combine and cut EGA/EMSA and reduce funding by 1/3 (this is the Governor's original proposal) Unknown	Eliminate GA, EGA and EMSA and fund the Adult Assistance Program at approximately 75% of the previous level Unknown	4 – indirect impact Funds to clients; some discussion about giving counties block grants
Continuing Care	--	New requirement for informal meeting for all waiver and PCA assessments prior to appeal.	--	3 – new mandate
Continuing Care	Cap Home and Community Based waivers - No new waiver slots, but if slots open, they can be filled.	Cap Home and Community Based waivers - $383 M savings (retroactive to March 2010) prohibits counties or DHS from cutting rates; commissioner may reallocate waiver dollars among counties.	Cap HCBS waiver spending -- About $100 M savings (no new waiver slots, if slots open they are not filled)	5 – unknown impact at this time. RED FLAG – Potential impact is that if State redistributes allocation yet counties have no tools to manage; 100% over expenditure is county responsibility
Health Care		Counties must reassess for MNCare		3 – new mandate

		eligibility every 6 months instead of 12 months, within current allocations (House Article 7, Section 44)		Additional work no addition revenue to offset
Health Care	--	MA application timelines -- Obligates counties to process MA applications for 65 and older within 45 days and for disabled within 60 days. Failure to meet timelines results in county liability for the entire non-federal cost of MA services (Article 7, Section 33)	--	3 – new mandate Counties will not take risk and will auto deny at 44 days. Will impact clients and facility payments.
Health Care	--	Cap Fee for Service spending - $216 M savings	--	4 – indirect impact
Health Care	Implements MA Expansion, includes some rate cuts (delay hospital rebasing, reduce basic care, reduce transportation)	Suspend MnCare coverage for adults with income above 200% fpg. Includes some rate cuts (delay hospital rebasing, reduce basic care, reduce transportation).	Eliminate MnCare Coverage for adults with children and income > 75% fpg adults without children and income >75% effective 1-1-12 Restore GAMC and CCDS Repeal Expansion of MA for adults without children – 10-1-11	4 – indirect impact Impact to clients; senate version goes back to model of 4 metro hospitals
Health Care	--	Tightens definition of “emergency medical services” that can be provided to non-citizens	Tightens definition of “emergency medical services” that can be provided to non-citizens	4 – indirect impact Impacts people we serve
Health Care	--	--	Eliminates the “optional” MA services, physical therapy, OT, Speech , chiropractic, eye	4 – indirect impact Impacts people we serve

			glasses, prosthetics and dental	
Health Care	--	Apply for federal "global" waiver -- $300 M savings	Apply for federal "global" waiver - assumes $654 M savings coupled with the Healthy Minnesota Defined Contribution Program	5 – unknown impact at this time.
Health Care	--	Cut payments to prepaid health plans by 12% - $348 M savings	Gov's recommendations for managed care reforms – admin cap and competitive bid (reduces health plans in metro area to two)	5 – unknown impact at this time.
Health Care	--	Healthy MN Defined Contribution Plan - adults in MnCare with income above 133% fpg	Healthy MN Defined Contribution Plan - MnCare enrollees with income above 75% fpg	5 – unknown impact at this time.
Public Health	Includes $40M for SHIP	Does not fund SHIP Grant dollars would go away and activities associated would as well.	Does not fund SHIP Grant dollars would go away and activities associated would as well.	2 – direct county funding cut
Public Health	--	--	Eliminates the TANF home visiting funding for CHBs and tribes ($15.7 M). Decrease to revenue budget by an estimated $340,000	2 – direct county funding cut Decrease to revenue with no corresponding decrease in responsibilities
Public Health	--	--	Eliminates the Family Planning Special Project grants ($7.412M) and prohibits MDH from applying for federal funds for family planning.	2 – direct county funding cut
Public Health	--	--	Eliminates lead-related funding (MS 145.925).	2 – direct funding cut, but to limited number of

				counties/cities
Public Health	--	--	Eliminates community tobacco grants ($6.442M)	4 – indirect
Public Health	--	--	Eliminates the Eliminating Health Disparities grants.	4 – indirect

Prohibits counties from negotiating supplementary services rates with providers of group residential housing, that do not enforce a policy of sobriety on their premises

Central Client Area – CCA . . .

Shelley Saukko

Just a quick update this month.

Initial Intervention Unit (IIU) members are now relocated a second time, having set up quarters in Rooms 608-609. Upgrades are being made to their HVAC system, computer lines, and space. During this construction time, all meetings have been moved out of those conference rooms to different locations.

Architects have met with division managers during the last month to get input on how GSC should be configured when all tenants, who are not county departments, move out. This long range master plan will take some time to form and will incorporate the original 2003 Master Plan, as well as the input we and other departments will be providing.

Construction is going well with timelines still being met on the CCA. Every now and then the door will be ajar, allowing a glimpse inside. The space is beginning to take on its final shape and imagining the finished product is a little easier.

Child Support: Just the Facts (and Figures) . . .

Melody Swenson

Our economy continues to struggle, gas prices continue to rise, and government spending and budgets are in the forefront of conversation at home and at work. As these issues all deal with the "bottom line" and our individual and collective pocketbooks, I am going to share some numbers and facts with you about the Child Support program in Minnesota and in St. Louis County. But, before I give you some facts and figures, just a reminder that the mission of the child support program is to promote the well-being of children and the self-sufficiency of families through the establishment of paternity, child support, medical support and child care orders and the enforcement of those orders through the collection of support. Also, note that parties who are receiving public assistance are required to participate with child support services, but people not receiving assistance also receive services from our program.

In Minnesota, state and county child support offices provide services for over 396,000 custodial and non-custodial parents and 256,000 children. In state fiscal year 2010, the Minnesota child support program had approximately 243,000 cases (of which 33,000 were public assistance cases). Of the remaining 210,000 cases, 58% had been public assistance cases at some time. Statewide, 174,000 children who have a child support case were born outside of marriage.

In 2010, our St. Louis County Child Support Offices in Duluth, Virginia, and Hibbing had 11,758 cases (this was an increase of 209 cases from 2009). In St. Louis County, our program maintains 43.9 child support officer, support staff, and supervisor positions (including a portion of an accounting position and a portion of our FAD director's position) and also maintains 8 positions in the County Attorney's Office (a total of 51.9 FTE's are part of our program costs). Statewide child support expenditures for SFY 2010 were $165 million. The Federal government matches 66% of state and county spending on the child support program and provides funding based on performance outcomes, which is passed on to the counties. Of the total state expenditures in SFY 2010, the Federal government funded 74%, the state, 8%, and the counties, 18%.

In Minnesota in SFY 2010, the child support program collected and disbursed approximately $606 million in current and past due support payments. Of that amount, $458 million was collected for ongoing support. Statewide, the average amount of support collected per open case with a court order was $2,916. The child support program collected and disbursed $10.8 million in child support to families receiving Minnesota Family Investment Program (MFIP) benefits, thereby reducing the cost of public assistance issued. In St. Louis County, we collected $25,930,974.27 in support during SFY 2010. Employer income withholding resulted in $411 million in child support payments statewide. Federal and state tax refund and rebate interceptions accounted for $38.6 million in SFY 2010 (6.3% of collections). Collection of support through financial institution data matches (levies) on assets and accounts totaled $21.7 million statewide. In St. Louis County financial institution data matches resulted in a total of $98,240.46 being collected. The state suspended a cumulative total of 86,000 driver's licenses of parents who failed to pay their child support. Other enforcement remedies used to collect support include recreational license suspensions, occupational license suspensions, passport denials, credit bureau reporting and contempt of court actions. All of those remedies contributed to the collection of support totals, as well as direct payments made by non-custodial parents.

Automation and technology have enabled parents to access information about the child support program and their case twenty-four hours a day, seven days a week. Parents can find information about their case and monitor their payments through the secure state website www.childsupport.dhs.state.mn.us/Action/Welcome . That site was used an average of 175,400 times per month last year. Approximately 90% of child support payments are sent to custodial parents through direct deposit into their savings, checking, or stored value accounts. There also is a Web-based calculator which allows someone to enter information and determine child support amounts (to see, for example, if their presently ordered obligation may meet the criteria to be increased or

decreased). The site, www.childsupportcalculator.dhs.state.mn.us had 468,000 hits in 2010.

In these difficult economic times, continuing to collect support for families and children remains the mission of the child support program. The child support program continues to provide a lot of "bang for the buck" in Minnesota and St. Louis County. In FFY 2010, the St. Louis County child support program collected $5.55 for every $1 spent on efforts in support of children where obligations were ordered in St. Louis County. The services that the child support program provides in Minnesota, as well as St. Louis County, are invaluable. The investment of resources and time in the collection of support has both tangible and intangible positive results. The collection of support is able to improve the standard of living for children, help families remain self sufficient, and can prompt both parents to be involved financially and emotionally in the lives of their children.

What's In a Name? . . .

Terry McCabe

I became familiar with E Fuller Torrey, M.D. as an Adult Mental Health case manager. I routinely shared his book, "Surviving Schizophrenia" with families. E Fuller Torrey, M.D. is a research psychiatrist specializing in schizophrenia and manic-depressive (Bipolar) illness. He is the founder of the Treatment Advocacy Center (www.TreatmentAdvocacyCenter.org) and the Executive Director of the Stanley Medical Research Institute which supports research on schizophrenia and manic-depressive (Bipolar) illness. Dr. E Fuller Torrey's sister suffered from schizophrenia.

Patients, Clients, Consumers, Survivors, Et Al: What's in a Name?

E. Fuller Torrey, M.D.
(*Published in Catalyst~Fall 2010)*

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently invited a dialog about words that are used for individuals with various forms of mental illness and their treatment. For example, what should we call people with schizophrenia? Patients? Clients? Consumers? Survivors? Schizophrenics? People with schizophrenia? People with lived experience? The words we choose are important, for, as Henry Ward Beecher noted, "words are pegs to hang ideas on." In deciding what words to use, a logical starting point is to ask what schizophrenia is. The answer, which has become overwhelmingly clear in the past 2 decades, is that schizophrenia is a disease of the brain. It exhibits abnormalities of the structure and function of that organ, just as diabetes does in the pancreas, hepatitis does in the liver, and emphysema does in the lungs. Some skeptics have argued that the brain abnormalities observed in schizophrenia are secondary to medications used to treat the disease, but these same abnormalities are found in patients who have never received treatment. A 2002 article reviews 65 such studies, and at least that number of similar studies have been published in the intervening years. Given these findings, it seems logical to follow medical tradition and call people with such abnormalities people with schizophrenia. And if they have received treatment, they can be called patients.

Given what is now known, why should we use alternate terms such as “client,” “consumer,” or “survivor”? Where did these terms come from? “Client” was apparently borrowed from Carl Rogers’ 1951 book, Client-Centered Therapy, which describes a technique of psychotherapy for individuals with disorders other than schizophrenia.

Both “consumer” and “survivor” are products of the 1970s, when the medical basis of schizophrenia was less clearly defined. Thomas Szasz claimed that schizophrenia did not even exist, Ronald Laing argued that it was a growth experience and Ken Kesey popularized the notion that schizophrenia was caused by putting people into mental hospitals. Out of this intellectual mélange emerged groups such as the Mental Patients Liberation Front and the Network Against Psychiatric Assault, and terms such as “consumer” and “survivor” came into use.

Client” is defined by Webster’s dictionary as “a customer,” especially of legal or accounting services. It thus implies one who voluntarily seeks services. The term is widely used by psychosocial rehabilitation services, such as clubhouses, where individuals do indeed voluntarily seek services. In that voluntary context, it seems appropriate.

“Consumer” is defined by the dictionary as “one who consumes, spends, wastes or destroys.” It has a quintessentially American ring to it, evocative of Walmart and maxed-out Visa cards. It conveys the idea that individuals who are receiving psychiatric services should have choices and should participate in the decision making, an important and useful concept insofar as those who have schizophrenia are aware of their illness and thus able to make choices. Unfortunately, it is now clear that in approximately half of all individuals with schizophrenia, the disease affects brain areas that govern self-awareness. Such individuals are largely unaware of their own illness, deny that anything is wrong, and refuse all treatment. This condition is well known among neurologists and referred to as anosognosia; we even know that parts of the brain that are affected and cause this deficit. “Consumer” is thus not a useful term for people with schizophrenia, because it refers to only the half of individuals with this disease who are aware of their illness and it excludes the others.

“Survivor” is defined in the dictionary as “one who exists after the death of another, or after some event of time.” The term is used by psychiatric patients, not like “cancer survivor” but in a more menacing sense like “rape survivor” or “Holocaust survivor.” It implies survival of traumatic event, specifically in this case involuntary treatment for a psychiatric illness. A major goal of the National Association of Psychiatric Survivors, organized in the 1980s, is to abolish all involuntary treatment. Such a goal ignores the needs of those individuals with schizophrenia who are unaware of their illness and who, because they are not being treated, are regularly victimized and end up homeless and/or incarcerated. Thus, “survivor,” like “consumer,” applies to only some individuals and is not all-inclusive. To use such terms ignores that needs of those to whom it does not apply and is thus a form of discrimination.

Despite this, “consumer” and “survivor” have become surprisingly politically correct and have been adopted by government and independent agencies. The federal government

under SAMHSA has a national Advisory Council Subcommittee on Consumer/Survivor Issues and uses public funds to support a National Mental Health Consumers' Self-Help Clearinghouse. At the state level there are organizations such as the Mental Health Consumer/Survivor Network of Minnesota. The National Alliance of Mental Illness has a Consumer Council. There is even a National Association of Consumer/Survivor Mental Health Administrators under the parent Nation Association of State Mental Health Program Directors.

The latest term being used for people with schizophrenia and other severe psychiatric disorders is "people with lived experience," sometimes abbreviated "PWLE." It is being increasingly used by groups funded by SAMHSA. For example, the website of the SAMHSA-funded National Empowerment Center states that "a consumer-driven system means one which is guided by people with a lived experience." Another SAMHSA-supported program, for mentally ill veterans, claims: "These activities present new and exciting opportunities for people with lived experience to become actively involved in reshaping policies and practices that impact upon their daily lives." Similarly, a 2006 article in a rehabilitation journal is titled: "Recovery from severe mental illness: the lived experience of the initial phase of treatment."

At first glance, it is unclear what is meant by "people with lived experience." It surely is not meant to distinguish this group of people from people with non-lived experience with lived experience. Because all living people have experience, the term seems like a creation of Lewis Carroll. In reading the literature in which "people with lived experience" is used, however, it is apparent that most of the time the term meant to imply that the delusions, hallucinations, and other symptoms experienced by individuals with schizophrenia are merely part of a spectrum of human experience. It is thus an implicit refutation of the medical model of disease. Carried logically forward, it suggests that diabetes is not a disease but merely a "lived experience" of having a high blood sugar level. In fact, the underlying intent of using most of these alternate terms for people with schizophrenia is a challenge to the idea of schizophrenia as a brain disease.

Using terms of schizophrenia that imply that it is not a disease is also inherently inconsistent at a personal level. Most individuals with schizophrenia, including those promoting terms such as "people with lived experience," are receiving medical disability benefits such as Supplemental Security Income, Social Security Disability Insurance, and veteran's disability pensions. They are receiving these benefits because they have been diagnosed as having a disease. Logically, if they do not believe that they really have a disease, they should not apply for, or accept, such benefits. They also should not be eligible for parity under insurance laws because parity refers to being treated equally with other diseases, not with other "lived experience."

Thus, to use the term "people with lived experience" to refer to people with schizophrenia is inaccurate, contradicted by more than a hundred recent studies that clearly establish schizophrenia as a brain disease. Similarly, the terms "client," "consumer," and "survivor" are discriminatory to use as general terms because they exclude the half of individuals with this disease who are unaware of their illness. The

clearest and most accurate term to use for people who are afflicted with schizophrenia is “people with schizophrenia.”

What about the term “schizophrenia”? Once widely used, it has been prohibited by the SAMHSA word police and by some state departments of mental health that have decreed only “people first” terminology to be politically correct. Like “diabetics,” “alcoholics,” and “epileptics,” “schizophrenics” can usefully indicate a group of people with a common condition, and some individuals with schizophrenia refer to themselves this way. Thus, for some, it may be a perfectly acceptable term.

Henceforth, then, I will personally use only terms that are both inclusive of all individuals with schizophrenia and scientifically accurate. And because SAMHSA has opened a public dialog on this issue, this seems like an opportune time for federal agencies to correct their use of improper terminology. Indeed, it seems bizarre for one federal agency – the National Institute of Mental Health (NIMH) – to be supporting research projects to understand the causes of a brain disease that another federal agency – SAMHSA – is describing in discriminatory and misleading terms, especially because both SAMHSA and NIMH are part of the Department of Health and Human Services. Let us then propose that “client” be used only in the context of psychosocial rehabilitation services and that “consumer,” “survivor,” and “people with lived experience” be abolished from all federal publications when they are used to refer to people with schizophrenia. They can be consigned to the junk heap of lexicographic history.

If You’re Over Age 49 . . .

Guy Peterson

Good news! The FDA just approved Zostavax vaccine for the prevention of shingles in individuals 50 to 59 years of age. This is a very good thing.

I remember in college when we were learning and memorizing so many different medical phenomenons; causes, effects, cellular biology, pathophysiology, etc., people would often get the heebee jeebees when certain ailments were described in detail. The thing that always got me was shingles. About the only way people would ever describe it was PAINFUL! Oh, we were suppose to remember it was a viral infection that some old people got from a long-dormant chicken pox virus, but then would come that description of PAINFUL. Pretty much they’d say there was no other pain in the world compared to the pain experienced by a person afflicted with shingles. That kind of description, at least the way it was explained to me, sort of gets your attention. I hoped I never got shingles.

This many years later, I kind of forgot about those guys. I was reminded a few seasons back when my wife, a young 50-something, healthy specimen thought she was experiencing “muscle spasms” when we were away on a fishing trip on a beautiful September getaway. Her back hurt around her shoulder blade. Then it continued to hurt the next day, and then the next. Massage or Tylenol seemed to make no difference. We headed back to town on Sunday afternoon and what did we discover

once home? A blistery rash from the middle of her back to beneath her arm pit. Not good.

To the doctor the next day. One, she wanted to know what the heck was going on, and two, what's with this PAIN? She couldn't get in to our regular doctor that day, but the young, new physician standing in had no problem figuring this out. By then, the rash had wrapped around her body to her breastbone. Classic: She had shingles. The doctor prescribed an antiviral drug, hoping it wasn't too late (they're only effective in reducing the severity and duration if started within 72 hours) and a big bottle of hefty pain pills. When I got home my wife was convinced that this doctor didn't know what she was talking about. No way could she have shingles!! That's when I dug out the books and we dropped in on the internet to re-visit what I had learned so long ago.

The illness is caused by the same virus that causes chickenpox (varicella zoster virus). Unlike many viruses that your body kills off for good, this one lies dormant in nerve cell bodies and sometime the dorsal root of the nerve. For some reason (unknown), it often "wakes up" many years later and travels down the nerve axons causing a new viral infection. Thus the pain. Inflammation just about anywhere smarts, but what kind of tissue, what kind of cells do you think would respond more to a stimulus than nerves, nerve roots, etc.? They're the grand-dad receptors of the whole body. If anything can feel pain, nerve cells can. The common name, shingles, derives from the Latin cingulus meaning "girdle" after the belt-like dermatomal rash. Although it can occur anywhere on your body (the face is the worst), it usually appears as a band of blisters that wraps from the middle of your back around one side of your chest to your breastbone (that's how the nerves run from your spine). The severe pain can last from several weeks to years (usually 4-6 weeks). The longer lasting version, called postherpetic neuralgia, occurs in about 10 % of those who get shingles.

A vaccine (Zostavax) was discovered and first approved in 2006. Trouble is, it was only tested on people age 60 and older, so that's all it has been licensed for so far. About one million people per year get shingles in the USA and about one-half of them are over age 60. It's said that one out of two people living to age 85 will have shingles. Anyway, after a number of years of people pointing out that this vaccine is needed for folks age 50-59, the company and FDA began testing. They found that the vaccine works even better on the younger folks (reduced outbreaks by 70% and lessened the severity and duration to the others) and continues to be safe.

My poor wife began the antivirals too late. They didn't work. She then, unfortunately, developed postherpetic neuralgia and continued to experience pain, itching, tingling and burning for a long, long time. Her symptoms have not completely left. They still bug her a year and a-half later. I phoned my doctor this week. I got an appointment for a Zostavax immunization. Love those immunizations.

Facilities Update . . .

GSC — Mark Zapp

Construction for the new Central Client Area is progressing along.

The IIU unit began moving Thursday March 31st and will finish on Friday April 1st. Most of the staff have relocated to room 608/609 with three others relocating into the IT office space (room 611).

Arvig — Mark Zapp

No report this month.

Range Offices — Lori Bouchard

No report this month.

Personnel Transactions . . .

New Hire	Job Title	Date	Unit
Corinn Griffiths	PHN I	3/14	Luzette Samargia
Katherine Karakash	SW MSW	3/7	Jim Kellner
Merry Johnson	FW	3/28	Sue Tonko
Jesica Matzdorf	FW	3/28	Mike Theno

Transfer	Job Title	Date	Old Unit/New Unit
Martha Karish	SW	3/14	Bottoms/Lawrence

Retirement	Job Title	Date	Unit
Sandy Hanken	SW CPS	3/25	Paula Stocke
Sharon Mount	FW, Sr.	3/31	Deb Lawrence

Years of Service

Congratulations to these individuals who have achieved these years of service in 2011:

	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
January	Debra Marturano Kelly Wilson	Mary Prudhomme	Candace Bruno	Renee Kailanen	---	Angela Noll
February	Brenda Gams	Katherine Bates Roberta Webb Elizabeth Zissos	---	Laura Bachschneider Brenda Jurek Christine Sheff	---	Georgina Knezevich
March	Bob Hess Ashley Matheson Melinda Nelson Marcia Ryss Wendi Tvedt	---	Ann Busche	Terry McCabe Noreen Lee	---	Candace Keane
April	Tammy Carlson Laura Kuettel Matthias Norenberg Nichole Rahman	Christina Heazlett	---	Lori Bouchard	---	---

	31 Years	32 Years	33 Years	34 Years	35 Years	36 Years
January	**---**	David Glesener Patricia Lien Janet Nilsen Barbara Peterson	Gladys Billeter Donna Wauzynski	Sally Hirsch JoAnn Stillman	Colleen Michaelson	Carol Rilling Velura Kellner (12/10) Rosanne Kocjzncich (12/10)
February	Michael Baddin Sandra Henkel-Johnson Joan Rice Judy Thorson	Diane Zavodnik	---	---	Sandra Grecinger Michele Rolandson	---
March	---	Sandra Caywood Gloria Niebuhr	Sharon Mount Donna Sokoloski	---	---	Sharon Hakkila Robert Masich
April	Lori Hill	---	Anita Sormunen	Donna Isaacson Carol Mackie	Lynda Klimek	---

	37 Years	38 Years	39 Years	40 Years	41 Years	42 Years
January	Sandra O'Brien	---	Robert Cohn	---	---	---
February	---	---	---	---	---	---
March	Karen Johnson Libby Welsh	Patricia Kruschke	---	---	---	---
April	Linda Stephenson	---	---	---	---	---